| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Health Resurvey. | F 000 | | |
| F 205 SS=D | 483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR<br><br>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.<br><br>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 33 with 15 residents sampled.<br><br>Based on interview and record review, the facility failed to provide a written bed hold notification at the time of transfer for one resident reviewed for bed hold. (#11)<br><br>Findings included:<br><br>- Nurses notes revealed the facility transferred resident #11 to an acute care facility on 3/28/13. | F 205 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 205 | Continued From page 1<br>The facility notified resident #11's DPOA (Durable Power of Attorney) of the transfer, however, the facility failed to provide written notice of the bed hold.<br><br>During an interview on 9/23/13 at 2:40 p.m., Administrative staff A confirmed that residents and families were given a copy of the bed hold policy on admittance to facility but not at the time of transfer to a different facility.<br><br>The facility failed to provide a written bed hold notification at the time of transfer for resident #11. | F 205 | | |
| F 225 SS=E | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must | F 225 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 225 | Continued From page 2 | F 225 | | |

prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This Requirement is not met as evidenced by:
The facility reported a census of 33 residents.

Based on interview and record review, the facility failed to report all alleged violations involving mistreatment, neglect, or abuse (related to resident to resident altercations) immediately to the state survey and certification agency.

Findings included:

- Review of the facility's abuse, neglect, and exploitation investigations revealed on 3/14/13 at 8:00 p.m., resident #34 and his/her spouse (a previous resident) walked in the facility hallway and staff witnessed resident #34's spouse hit him/her with hard force. Staff intervened to protect resident #34 and after assessing both residents, notified the physician/family of the incident. The facility transferred resident #34's spouse for treatment to a local psychiatric hospital. The investigation lacked evidence that the facility immediately reported the incident to the state survey and certification agency.

Review of the facility's investigations revealed on 4/9/13 at 9:05 p.m., staff witnessed resident #1

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 225 | Continued From page 3 | F 225 | | |

following resident #26 who carried a trash can in his/her hands. Resident #1 grabbed the trash can and pushed resident #26 into the wall and resident #26 fell. Staff intervened, assessed both residents for injury, and notified the physician/family of the incident. The investigation lacked evidence that the facility immediately reported the incident to the state survey and certification agency.

Review of the facility's investigations revealed on 8/13/13 at 7:30 p.m., staff noticed resident #14 crying in her room. Administrative Nursing Staff B checked on the resident and asked what upset him/her. Resident #14 reported his/her roommate, resident #26, hit him/her on the head with a remote control. Staff B assessed resident #14 and found no injuries. After alerting resident #14 and #26's physician and family of the incident, and after obtaining permission, moved resident #14 to another room. The investigation lacked evidence that the facility immediately reported the incident to the state survey and certification agency.

Review of the facility's investigations revealed on 8/23/13 at 6:45 p.m., resident #2 and #29 sat in wheelchairs in the dining room close to one another. Staff witnessed resident #2 hit resident #29 on the arm. Nursing staff separated the residents, assessed both residents for injury and reported the incident to the physician/family. The investigation lacked evidence that the facility immediately reported the incident to the state survey and certification agency.

During an interview on 9/19/13 at 9:41 a.m., Administrative Nursing Staff B reported he/she investigated allegations of abuse, neglect, and exploitation. Staff B verified that each resident to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 225 | Continued From page 4<br>resident altercation needed to be reported to the state, including the incident between resident #34 and his/her spouse, between resident #1 and #26, between resident #14 and #17, and between resident #2 and #29.<br><br>During an interview on 9/23/13 at 3:17 p.m., Administrative Staff A reported he/she thought the facility should only report resident to resident altercations to the state agency if a resident obtained an injury during the incident.<br><br>The facility's "Abuse, Neglect, and Exploitation" policy, revised on 5/22/02, instructed staff that "all alleged violations will be reported to the State and other appropriate agencies" but lacked mention to report such allegations or incidents immediately.<br><br>The facility failed to immediately report altercations to the state agency between resident #34 and his/her spouse that occurred on 3/14/13, residents #1 and #26 that occurred on 4/9/13, residents #14 and #17 that occurred on 8/13/13, and residents #2 and #29 that occurred on 8/23/13. | F 225 | | |
| F 226 SS=C | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 33 residents.<br><br>Based on observation, interview, and record review, the facility failed to implement their written | F 226 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 226 | Continued From page 5<br>policy and procedure that prohibited mistreatment, neglect, and abuse of residents and misappropriation of residents' property when staff failed to develop a system to monitor results of background checks for newly hired employees. The facility also failed to update policies to assure compliance with Section 1150 B of the Social Security Act related to "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility", referenced in the Survey and Certification letter 11-30-NH, dated 6/17/11 and revised on 8/12/2011.<br><br>Findings included:<br><br>- Review of personnel files revealed the facility hired the following staff and submitted a request for criminal background checks:<br>* Direct Care Staff P: hired on 7/30/13 and signed consent for criminal background check on 8/5/13<br>* Direct Care Staff Q: hired on 7/30/13 and signed consent for criminal background check on 8/5/13<br>* Dietary Staff J: hired on 8/9/13 and signed consent for criminal background check on 8/9/13<br>* Dietary Staff R: hired on 8/28/13 and signed consent for criminal background check on 8/28/13<br>* Direct Care Staff S: hired on 8/29/13 and signed consent for criminal background check on 8/29/13<br><br>Review of Direct Care Staff P, Q, and S's personnel files revealed the facility printed verification of active certification as nurse aides from the state registry. The verification indicated the registry reviewed criminal background check in the past on 7/6/10 for Staff P, 7/5/10 for Staff Q, and 10/9/08. Review of the personnel files for | F 226 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 226 | Continued From page 6<br>Staff P, Q, J, R, and S on 9/19/13 lacked evidence of the results of the criminal background checks after the above submission dates from the facility.<br><br>During an interview on 9/23/13 at p.m., Administrative Staff A reported he/she submitted criminal background checks after receiving consent from the new employee, such as for Staff P, Q, J, R, and S. Staff A reported he/she checked the online state nurse aide registry for Direct Care Staff P, Q, and S, noted if a criminal background check had been submitted in the past and verified that results should be current. Staff A reported he/she checked an online service for results of Staff J and R's criminal background checks, could not locate their names, and stated that meant that the employee had a clear criminal record. Staff T verified that the facility needed current results of criminal background checks for all newly hired staff.<br><br>The facility's untitled and undated policy related to background checks instructed staff that "all new hires will have a criminal history check" and "at the time of hire, the administrator will ask the employee to sign 'Authorization for release of information'. The administrator will then access the [state] website for criminal history of the new employee."<br><br>The facility's "Abuse, Neglect, and/or Exploitation" policy, revised on 5/22/02, instructed to "screen potential employees for history of abuse, neglect, and exploitation."<br><br>The facility failed to develop a system to monitor results of background checks for newly hired employees. | F 226 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 226 | Continued From page 7<br>- During a tour of the facility on 9/19/13 at 3:21 p.m., the facility lacked evidence of providing notification to employees of their reporting obligations related to suspicion of a crime.<br><br>Review of the facility's "Abuse, Neglect, Misappropriation of Property" policy, revised on 5/22/02, revealed the policy failed to include the Long Term Care Facility's responsibilities included in Section 1105 B of the Social Security Act as related to Federal requirements for reporting reasonable suspicion of a crime to local law enforcement.<br><br>During an interview on 9/23/13 at 3:17 p.m., administrative nursing staff A confirmed the current facility Abuse, Neglect, and Exploitation policy lacked the required information included in the S & C letter 11-30. The current facility policy did not include information regarding reporting reasonable suspicion of a crime in a long term care facility to assure compliance with the requirement.<br><br>The facility failed to incorporate and implement all requirements of Section 1150 B of the Social Security Act related to "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility", referenced in S&C letter 11-30-NH into their Abuse, Neglect, and Exploitation policy. | F 226 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This Requirement is not met as evidenced by:<br>The facility had a census of 33 residents. The | F 253 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 253 | Continued From page 8<br>facility had 3 hallways: McClain, McMurry, and Parker. Each hallway had a bathroom for resident use.<br><br>Based on observation and interview, the facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary interior (dust build-up on ceiling vents in bathrooms used by residents on McMurry and Parker; dust build-up on ceiling vents in 2 resident rooms on McMurry).<br><br>Findings included:<br><br>- An observation on 9/17/13 at 12:15 p.m. of a resident bathroom on McMurry hallway revealed dust accumulation on the ceiling vent. An observation on 9/17/13 at 2:30 p.m. of another resident room on McMurry hallway also revealed dust build-up on the ceiling vent in the bathroom.<br><br>During an observation on 9/23/13 at 9:30 a.m., the ceiling vent in the commons bathroom used by residents on McMurry hallway had a heavy accumulation of dust. An observation of the commons bathroom used by residents on Parker hallway also revealed a heavy accumulation of dust on the ceiling vent.<br><br>During an interview on 9/23/13 at 10:15 a.m., maintenance staff F revealed he/she did not routinely check the ceiling vents for cleanliness and cleaning of the vents were not on a cleaning schedule.<br><br>The facility failed to maintain clean ceiling vents in bathrooms used by residents. | F 253 | | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION | F 318 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 318 | Continued From page 9<br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 33 residents with 15 residents sampled for review and 1 resident reviewed for range of motion.<br><br>Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident reviewed for range of motion received appropriate treatment and services to increase or prevent a decrease in range of motion. (#13)<br><br>Findings included:<br><br>- Resident #13's 9/1/13 physician's orders included diagnoses of multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord) and osteoporosis (disorder characterized by abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).<br><br>Resident #13's 7/3/13 Quarterly MDS (Minimum Data Set) Assessment reported the resident had no cognitive impairment and needed total assistance from two staff for bed mobility, transferring, and toilet use. The resident had limited range of motion in all limbs and received restorative nursing services that included passive and active range of motion 4 days of the observation period. | F 318 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 318 | Continued From page 10<br>Resident #13's 10/29/12 ADLs (Activities of Daily Living) CAA (Care Area Assessment) summary reported the resident had multiple sclerosis that limited his/her range of motion and needed total assistance with most of his/her cares.<br><br>Resident #13's 7/11/13 care plan instructed staff that the resident needed total assistance with his/her ADLs due to multiple sclerosis. Interventions on the care plan to prevent further decline included restorative exercises while the resident laid in bed 2 to 5 times a week. The care plan listed the exercises that staff performed as upper and lower extremity passive range of motion with a "t-bar" (an assistive device for exercises), a "t-band" (an assistive device for exercises), and "dexterity" (an assistive device for exercises). The care plan informed staff that the resident "rarely chose to ride a personal MOTO [a motorized stationary bicycle that moved automatically] bike".<br><br>Review of resident #13's "Long Term Care Restorative Aide Monthly Record" revealed that staff failed to document whether the resident refused or received restorative services from 7/24/13 to 8/1/13 (a period of 9 days). Restorative nursing documented that the resident refused all restorative exercises on 8/2/13. Staff failed to document that the resident received or refused any restorative services between 8/3/13 and 9/18/13 (a period of 47 days).<br><br>During an observation on 9/17/13 at 4:25 p.m., resident #13 laid in bed with contracted (an abnormal permanent fixation of a joint) knees and elbows bent at 90 degree angles and he/she presented as alert and able to express his/her needs to staff. | F 318 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 318 | Continued From page 11 | F 318 | | |

During an observation on 9/18/13 at 3:49 p.m., Direct Care Staff H gave resident #13 a "t-bar" to hold in his/her hands and asked the resident to move the bar with his/her arms independently. Staff H held the top of the resident's right knee and the bottom of the resident's right foot and performed passive exercises by bending five times at the hip, then the knee, and then the ankle. Staff H repeated this process on the left leg. At 3:58 p.m., Staff H held the resident's right and left hand and performed passive exercises on the resident's arms by bending at the elbows, shoulders, and wrists. During the exercises, the resident displayed no outward signs of pain such as moaning or grimacing.

During an interview on 9/17/13 at 4:25 p.m., resident #13 reported he/she could no long move his/her legs and had difficulty moving his/her arms due to multiple sclerosis. He/she reported that no staff had stretched his/her legs or assisted with exercises on his/her arms in over a month.

During an interview on 9/18/13 at 1:15 p.m., Direct Care Staff T reported the facility had two restorative nurse aides, Staff H and him/herself. Staff T reported that he/she could not assist residents with restorative exercises due to being "light duty" for the past month. Staff T reported in the past, he/she stretched resident #13's legs 4 to 5 times a week, but did not know if Staff H had assisted resident #13 since Staff T had injured him/herself.

During an interview on 9/18/13 at 1:32 p.m., Direct Care Staff H reported he/she had not provide restorative services for resident #13 in at least a month. Staff H reported that usually Staff T assisted resident #13 and lacked awareness

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 318 | Continued From page 12<br>how often the resident should received restorative exercises. Staff H reported he/she had multiple duties, including transporting residents to and from appointments, organizing activities programs, and assisting other direct care staff with resident cares that interfered with his/her restorative duties. Staff H reported that at times, when direct care staff called in due to illness, restorative staff worked as direct care staff instead of providing restorative services.<br><br>During an interview on 9/23/13 at 2:41 p.m., Administrative Nursing Staff B verified that resident #13 received no restorative services as instructed in the resident's comprehensive care plan.<br><br>The facility failed to ensure resident #13 received range of motion services as care planned. | F 318 | | |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This Requirement is not met as evidenced by:<br>The facility had a census of 33 residents with 15 selected for sample. The facility identified 8 residents as cognitively impaired and independently mobile.<br><br>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 13<br>(uneven, pitted, and eroded sidewalks) for 1 of 2 residents sampled for falls. (#33) Resident #33 tripped on an uneven section of the sidewalk extending North in front of the facility and sustained a neck fracture on 7/23/13.<br><br>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards (unsafe gaps in side rails) for 1 resident sampled for side rails (#24) and for 2 non-sampled residents (#27 and #13).<br><br>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards (chemicals accessible to residents) for 8 cognitively impaired, independently mobile residents.<br><br>Findings included:<br><br>- Resident #33's 6/19/13 Significant Change MDS (MDS) assessment revealed the resident had a BIMS (brief interview for mental status) score of 15, which indicated intact cognition. The assessment also indicated the resident performed ADLs (activities of daily living) independently which included transfers, walking in the room and corridor, locomotion on and off the unit, and dressing. The resident used a cane for mobility.<br><br>Resident #33's 8/14/13 Significant Change MDS (after the fall on 7/23/13) revealed the resident had intact cognition and required supervision of 1 person for transfers, walking in the corridor, locomotion on and off of the unit, and limited assistance of 1 person for dressing. The resident used a walker and cane for mobility. | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 14<br><br>Resident #33's 8/22/13 ADL CAA (Care Area Assessment) summary stated the resident had a C-1 (1st vertebrae of the cervical spine in the neck area) fracture, used a C-collar (neck brace) to support the neck, and staff assisted the resident when outside. According to the CAA, an analysis of the 7/23/13 fall stated the resident walked outside of the nursing home in the dark, had difficulty seeing, and the resident fell on an uneven sidewalk.<br><br>The 8/22/13 care plan identified resident #33 as at risk for falls. The resident required supervision with ADLs, a C-collar placed on the resident neck at all times, and stated the resident should call for assistance for ambulation with a walker.<br><br>An accident investigation dated 7/23/13 at 6:00 a.m., by licensed nursing staff DD reported the resident was found lying on his/her right side on the east lawn. According to the report, the resident stated he/she tripped over the uneven part of the sidewalk and landed on his/her head. The resident complained of neck pain and the facility transferred the resident to the Emergency Room.<br><br>An 8/15/13 progress note written by physician BB stated resident #33 walked outside of the nursing home, tripped on the sidewalk, and fell. The fall resulted in a C-1 fracture, a brace was applied, and should be worn for 3 months.<br><br>During an observation on 9/18/13 at 3:20 p.m., resident #33 walked down the hallway of the facility independently with a C-collar in place on the resident's neck.<br><br>An observation on 9/23/13 at 9:30 a.m. of the | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 15<br>sidewalk in front of the facility revealed areas of pitted, eroded, and uneven walkways. The sidewalk area leading from the front entrance to the North/South sidewalk had 3 uneven areas. The sidewalk parallel to the facility that extended North had 2 areas of uneven surface and had pitted/eroded areas. The North sidewalk and the front entrance had patched/repaired areas in the concrete. The sidewalk parallel to the facility that extended South had an uneven area. The uneven surfaces and pitted/eroded areas posed a trip/fall hazard.<br><br>During an interview on 9/19/13 at 10:15 a.m., resident #33 stated he/she walked on the sidewalk on the North end of the building and said the concrete "was torn up and I tripped over it ".<br><br>During an interview on 9/19/13 at 1:50 p.m. direct care staff U stated resident #33 previously walked in the early morning. Staff U added that at the time of the fall the resident was independent with ambulation.<br><br>During an interview on 9/23/13 at 9:52 a.m., licensed nurse B stated that on the day the resident #33 fell, licensed nurse DD heard the resident calling out, assessed the resident had fallen, obtained vital signs, and called for emergency transport to the hospital for evaluation.<br><br>During an interview on 9/24/13 at 9:55 a.m., nurse practitioner CC stated resident #33 was very lucid (having full use of one's faculties) and independent with ambulation prior to the fall on 7/23/13. Nurse Practitioner CC stated the resident reported he/she tripped over the sidewalk outside on a broken piece of concrete. | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 16 | F 323 | | |

The resident presented to the emergency room with neck pain and tenderness over the vertebral bodies (spine). According to nurse CC, emergency care included placement of a C collar and the resident was flown to the Wesley Medical Center trauma unit for care.

The facility failed to ensure resident #33 remained free of trip/fall hazards when he/she walked outside. The sidewalks in front of the facility had pitted, eroded, and uneven surfaces. Resident #33 fell on 7/23/13 after tripping on the sidewalk and sustained a neck fracture.

- Resident #24's 9/1/13 physician's orders included a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

Resident #24's 7/24/13 Quarterly MDS (Minimum Data Set) Assessment reported the resident had short/long term memory problems with severely impaired decision making skills and continuous disorganized thinking and inattention. The resident needed extensive assistance of 2 staff with bed mobility.

Resident #24's 5/9/13 Cognitive Loss and ADLs (Activities of Daily Living) CAA (Care Area Assessment) summaries reported the resident experienced a decline in cognition since the prior assessment and needed increasing help with his/her ADLs.

Review of resident #24's clinical record lacked an assessment of bed rails related to safety hazards.

Resident #24's 8/1/13 care plan instructed staff that the resident needed extensive assistance with bed mobility and experienced increased

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 17 | F 323 | | |

forgetfulness and confusion due to advancing Alzheimer's disease. The care plan lacked mention of use of bed rails.

During an observation on 9/17/13 at 10:48 a.m., resident #24's bed had four quarter-sized bed rails and the two upper rails presented in the upright position. Each lower rail had an outer bar that had a large, trapezoid shape with 2 internal, vertical bars that had 3 gaps: the 2 outer gaps measured 5 inches long by 5 inches wide, the middle gap measured 5 inches long by 7 1/4 inches wide. Each upper rail had an outer bar with a trapezoid shape and one internal, vertical bar with two trapezoid shaped gaps that each measured 5 1/4 inches long by 6 inches wide.

During an observation on 9/17/13 at 4:25 p.m., non-sampled resident #13 laid in his/her bed and had two upper and two lower bed rails in the lowest position. Resident #13's bed rails had the same gap measurements as described on resident #24's bed above.

During an observation on 9/17/13 at 5:18 p.m., non-sampled resident #27 sat in his/her room recliner and his/her bed two upper and two lower bed rails in the lowest position. Resident #27's bed rails had the same gap measurements as described on resident #24's bed above.

During an observation on 9/19/13 at 3:08 p.m., resident #24 laid in his/her bed with the upper rails in the upright position.

During an interview on 9/19/13 at 3:08 p.m., Licensed Nursing Staff K reported resident #24 did not have an assessment related to the use of bed rails in his/her clinical record and should not have his/her bed rails in the upright position.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 18 | F 323 | | |

Staff K reported he/she knew that gaps in bed rails posed a risk for entrapment but stated he/she did not know the measurements that gaps should be to keep residents safe. Staff K confirmed that the facility did not assess bed rails for safety hazards on a routine basis.

During an interview on 9/19/13 at 3:12 p.m., Administrative Nursing Staff A confirmed resident #24, #13, and #27's bed rail had gaps that presented as potential entrapment hazards.

Although requested on 9/19/13 at 4:00 p.m., the facility failed to provide a policy related to bed rail safety hazards.

The Center for Devices and Radiological Health Guidance dated 3/2006 revealed that the Food Drug Administration recommended that the greatest side rail gap to prevent head entrapment was 4.75 inches.

The facility failed to ensure the resident environment remained free from potential accidents with the use of bed rails with large gaps that posed a potential for entrapment for residents #24, #13, and #27.

- During an initial tour of the facility on 9/17/13 at 9:19 a.m., the unlocked soiled utility room on Parker hallway had a spray bottle of Betco-Quat stat with 600 ml (milliliters) in the bottle labeled "Keep Out of Reach of Children".

An interview on 9/18/13 at 9:35 a.m. with administrative nurse B confirmed all chemicals should be secured in a locked cabinet.

The facility's 2010 revised Hazardous Chemicals policy stated, "Chemicals will be stored in locked

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 323 | Continued From page 19<br>cabinets."<br><br>The facility failed to ensure the resident environment remained free of accidents/hazards by storing potentially hazardous chemicals in areas accessible to 8 cognitively impaired, independently mobile residents. | F 323 | | |
| F 353 SS=F | 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.<br><br>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This Requirement is not met as evidenced by:<br>The facility had a census of 33 residents with 15 residents sampled.<br><br>Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff to provide nursing and related | F 353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 353 | Continued From page 20<br>services to attain or maintain each resident's highest practicable physical, mental, and psychosocial well being.<br><br>Findings included:<br><br>- A confidential resident interview on 9/1/7/13 at 4:29 p.m. revealed that on one occasion the resident called his/her spouse at home because staff did not answer the call light when he/she needed to go to the toilet. The resident also indicated he/she did not received restorative services and believed this was due to staffing problems.<br><br>A confidential resident interview on 9/17/13 at 4:40 p.m. revealed the resident waited 20-30 minutes for help to go to the bathroom.<br><br>During a confidential resident interview on 9/17/13 at 5:18 p.m., the resident stated he/she waited for 30 minutes and ended up going to the toilet by him/herself without staff assistance.<br><br>During an interview on 9/19/13 at 3:00 p.m., direct care staff N indicated the facility lacked adequate staff to provide the care and assistance needed by the residents. He/she stated residents do not get their baths like they should and stated staff will use the stand-up lifts with one staff person because other staff are busy feeding residents.<br><br>An interview on 9/23/13 at 11:53 a.m. with administrative nurse B revealed he/she recently scheduled additional direct care staff from 2 p.m. to 10 p.m. due to resident concerns regarding staff not answering lights in a timely manner.<br><br>An interview on 9/23/13 at 1:15 p.m. with direct | F 353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 353 | Continued From page 21<br>care staff L revealed when staff called in, the facility tried to get replacements, however, at times they worked short because they cannot find staff to come in.<br><br>During an interview on 9/23/13 at 1:50 p.m. licensed nurse C stated the facility recently added a 2 p.m. to 10 p.m. CNA (certified nurse assistant) to help during the busy time in the evening. Nurse C stated the mornings are also busy times and the residents may not get the care they need because of insufficient staffing.<br><br>- Based on interview and record review, the facility failed to report all alleged violations involving mistreatment, neglect, or abuse (related to resident to resident altercations) immediately to the state survey and certification agency as cited at F 225.<br><br>- Based on observation and interview, the facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary interior (dust build-up on ceiling vents in bathrooms used by residents on McMurry and Parker; dust build-up on ceiling vents in 2 resident rooms on McMurry) as cited at F 253.<br><br>- Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident reviewed for range of motion received appropriate treatment and services to increase or prevent a decrease in range of motion as cited at F 318.<br><br>- Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards (uneven, pitted, and eroded sidewalks) for 1 of 2 residents sampled for falls as cited at F 323. | F 353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 353 | Continued From page 22<br>- Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards (unsafe gaps in side rails) for 1 resident sampled for side rails and for 2 non-sampled residents as cited at F 323.<br><br>- Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards (chemicals accessible to residents) for 8 cognitively impaired, independently mobile residents as cited at F 323.<br><br>- Based on observation, interview and record review, the facility failed to provide food prepared by methods that conserved nutritive value by not following a recipe for 3 residents who received pureed diets as cited at F 364.<br><br>- Based on observation, interview, and record review, the facility failed to assure that 1 sampled resident received the therapeutic diet prescribed by the attending physician as cited at F 367.<br><br>- Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions when staff failed to properly as cited at F 371.<br><br>- Based on observation, interview and record review, the facility failed to maintain proper temperature control in the medication room refrigerator which has the potential to affect all residents as cited at F 431.<br><br>- Based on observation, interview, and record review, the facility failed to provide a safe, sanitary environment to prevent the spread of infection or disease when staff failed to properly | F 353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 353 | Continued From page 23<br>handle and process all residents' laundry, failed to properly dispose of soiled gloves and gowns after handling residents' dirty laundry, and failed to clean a resident's bathroom according to manufacturer's instructions. The facility also failed to properly utilize gloves while providing care as cited at F 441.<br><br>- Based on observation, interview, and record review, the facility failed to provide a safe environment (uneven, pitted, and eroded sidewalks posing a fall hazard) for residents, staff, and visitors as cited at F 465.<br><br>The facility failed to provide sufficient nursing staff to meet the needs of the residents. | F 353 | | |
| F 364 SS=D | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 33 residents. Three residents received pureed diets.<br><br>Based on observation, interview and record review, the facility failed to provide food prepared by methods that conserved nutritive value by not following a recipe for 3 residents who received pureed diets. (#24, 2, 11)<br><br>Findings included:<br><br>- During an observation on 9/19/13 at 11:20 a.m., Dietary Staff AA prepared pureed chili by adding | F 364 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 364 | Continued From page 24<br>4 scoops of chili and saltine crackers in the food processor.<br><br>During an observation on 9/19/13 at 11:46 a.m., Dietary staff W prepared pureed a cinnamon roll by adding 1/4 cup of milk and 1 large cinnamon roll.<br><br>During an interview on 9/23/13 at 10:30 a.m., Dietary staff D stated that no recipes were available for pureed foods and that staff used their own judgment by "eyeballing" the food being pureed.<br><br>During an interview on 9/23/13 at 2:00 p.m., consultant V stated he/she provided the facility with general guidelines, however, he/she did not provide specific recipes to follow for pureed foods. Consultant V confirmed he/she was unaware staff did not follow the guidelines.<br><br>The facility failed to provide food prepared by methods that conserved nutritive value for residents # 24, #2, #11, who received a pureed diet. | F 364 | | |
| F 367 SS=D | 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN<br><br>Therapeutic diets must be prescribed by the attending physician.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 33 with 15 residents sampled.<br><br>Based on observation, interview, and record review, the facility failed to assure that resident #19 received the therapeutic diet prescribed by the attending physician. | F 367 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 367 | Continued From page 25<br><br>Findings included:<br><br>- Resident #19's physician's order sheet, dated 9/1/13, revealed a diagnosis of chronic renal failure (inability for the kidneys to excrete wastes, concentrate urine and conserve electrolytes over a long period of time).<br><br>Resident #19's 8/7/13 Quarterly MDS (minimum data set) assessment revealed the resident had intact cognition, performed ADL's (activities of daily living) independently, and received a therapeutic diet.<br><br>Resident #19's 2/22/13 Nutrition CAA (care area assessment) summary revealed that the resident received a special diet of soft foods with low sodium and low potassium.<br><br>Resident #19's 8/16/13 revised nursing care plan instructed staff to offer him/her a snack off of the snack cart and monitor food intake 3 days prior to the MDS. The care plan further instructed staff to encourage the resident to limit high potassium food, low sodium diet, and monitor fluid status.<br><br>A physicians order, dated 9/1/13, revealed an order for a soft, low sodium, 2000 mg (milligram) low potassium diet with no tomatoes, watermelon, oranges or orange juice, and a 1500 cc (cubic centimeters) fluid restriction.<br><br>During an observation on 9/19/13 at 8:20 a.m., resident #19 sat in a recliner with a breakfast tray in front of him/her. The tray contained cereal, 1/2 banana (rich in potassium), a small glass of milk, a glass of ice water, and a slice of toast.<br><br>During an observation on 9/19/13 at 12:00 p.m., | F 367 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 367 | Continued From page 26<br>dietary staff AA prepared resident #19's tray with a bowl of chili with diced tomatoes.<br><br>During an interview on 9/19/13 at 1:50 p.m., direct care staff U revealed he/she was unaware if resident #19 was on a special diet.<br><br>During an interview on 9/23/13 at 2:00 p.m., dietary staff D confirmed that the dietary staff did not follow the physician ordered diet for resident #19.<br><br>The facility failed to assure that resident #19 received his/her physician prescribed therapeutic diet. | F 367 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This Requirement is not met as evidenced by:<br>The facility had a census of 33 residents. The attached hospital kitchen prepared and served foods for the Long Term Care Unit.<br><br>Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions when staff failed to properly:<br>* Maintain sanitation of equipment<br>* Monitor refrigerator/freezer temperatures | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 371 | Continued From page 27<br>* Change gloves and wash hands between tasks<br>* Serve food without contaminating dishware and glasses/cups<br><br>Finding included:<br><br>- An observation on 9/17/13 at 8:20 a.m. revealed:<br>* lime buildup on the top and sides of the dishwasher where the door opened and closed<br>* the stove backsplash had dark food debris burned on<br>* the sprinkler pipe inside the overhead oven hood had dust accumulation<br>* the backsplash behind the small oven had grease and food debris<br>* grease, food debris stained the glass on the small oven doors<br>* the temperature knob for the small oven had food debris around it<br>* the ice machine had hard water stains on the top, with water streaks running down the sides<br>* the inside lid of the ice machine had a small area soiled with a brown sticky substance approximately 3 inches in circumference<br>* the small chest freezer located in the food storage area had approximately 1 inch of frost on all 4 walls<br>* the air circulation vent on the inside top of the refrigerator had a fine dust covering<br><br>During an interview on 9/24/13 at 3:56 p.m., dietary staff D stated cleaning the equipment and kitchen areas should be accomplished as scheduled. Dietary staff D acknowledged empty spaces on the schedule represented the tasks had not been completed or had not been signed off by the staff member.<br><br>Record review of the kitchen for morning, | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 371 | Continued From page 28<br>afternoon, and monthly cleaning schedules revealed:<br>* the dishwasher should be cleaned with Lime-A-Way every Sunday, in September this had been done twice<br>* the oven canopies are scheduled for cleaning each Saturday, in September this has been done 1 time<br>* the small oven, the backsplash, and the temperature control knob should be cleaned every Thursday, in September this has been done 1 time<br>* the outside walls of the ice machine should be cleaned each Tuesday, in September this was done twice<br>* cleaning the inside of the ice machine was not listed on the cleaning schedule<br>* defrosting the small chest freezer was not listed on the cleaning schedule<br>* the refrigerator should be cleaned every Monday, in September this has been done twice<br><br>The facility failed to maintain sanitation of the facility equipment.<br><br>- An observation on 9/17/13 at 8:20 a.m. revealed the facility failed to record the temperature values for the refrigerator and freezer temperature logs twice each day.<br><br>During an interview on 9/19/13 at 11:20 a.m.,dietary staff AA stated the dietary staff recorded the temperatures of the refrigerator and freezer following the Refrigerator / Freezer Temperature Record time frames.<br><br>During an interview on 9/19/13 dietary staff D stated the Refrigerator / Freezer temperature Log should be completed twice a day. | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 371 | Continued From page 29 | F 371 | | |

Although requested, a policy and procedure for recording refrigerator and freezer temperatures was not provided by the facility.

The facility failed to properly monitor the temperature of the refrigerator and freezers.

- An observation on 9/19/13 at 11:50 a.m. revealed dietary staff J and W served meals and carried the plates with the same pair of blue gloves on. Each aide's thumb protruded beyond the rim of the plate. Staff handled the fruit and vegetable bowls by the rims.

An observation on 9/19/13 at 12:06 revealed dietary staff J prepared pureed fruit and 4 bean salad. Staff J handled resident menus with a pair of blue gloves on, and then failed to change the gloves prior to preparing the food.

The dietary staff failed to record at one of daily temperatures for the walk in freezer on the following days in September: 3, 4, 5, 9, 12, 13, and 14; for the small freezer on September 4, 5, 9, and 14; and for the refrigerator on September 5, 8, and 9.

During an interview on 9/19/13 at 12:00 p.m., dietary staff W explained the blue gloves were used to maintain cleanliness during the meal service.

During an interview on 9/23/13 at 10:30 a.m., dietary staff D stated the dietary staff should carry plates of food by the edges. Staff D stated the same pair of gloves should not be worn through the meal service.

Although requested, the facility failed to provide the policy and procedure for handwashing and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 371 | Continued From page 30<br>gloves use in the dietary department.<br><br>The facility failed to prepare and serve food in a sanitary manner.<br><br>- During an observation on 9/17/13 at 11:28 a.m. Dietary staff J and dietary staff W touched the rims of all the glasses served in the dining room. Dietary Staff J and W wore gloves that had touched the cart, backs of residents chairs and door knobs.<br><br>During an observation on 9/17/13 at 11:53 a.m., dietary staff J explained to resident #3 where items were located on his/her plate and touched the cornbread with contaminiated gloves to show him/her.<br><br>During an observation on 9/17/13 at 11:55 a.m., direct care staff H touched resident #3's cornbread with bare hands.<br><br>During an interview on 9/23/13 at 11:17 a.m., dietary staff D confirmed that staff should have changed gloves after they became contaminated by touching other items and that glasses are not to be served by touching the rim.<br><br>The facility failed to serve food under sanitary conditions. | F 371 | | |
| F 431 SS=F | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 31<br>reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 33 residents. The facility had one medication room and one medication cart.<br><br>Based on observation, interview and record review, the facility failed to maintain proper temperature control in the medication room refrigerator which has the potential to affect all residents.<br><br>Findings included: | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 32<br>- An observation 9/17/13 at 906 a.m. revealed a temperature of 51 degrees F (Fahrenheit) in the refrigerator in the medication storage room. The refrigerator contained insulin vials, insulin pens, and suppositories.<br><br>The Refrigerator Temperature Log posted in the medication room defined the desired temperature range of the refrigerator as 34 - 47 degrees F (Fahrenheit) and stated, "If not between these parameters adjust temperature dial and notify maintenance."<br><br>Although requested, the facility failed to provide refrigerator temperature logs for July of 2013. Review of the refrigerator temperature log for August 2013 revealed 26 out of 31 days with temperatures above the parameter of 47 degrees F ranging from 48 - 60 degrees F. Review of the September 2013 refrigerator temperature log revealed temperatures from 9/2/13 to 9/11/13 ranging from 48 degrees F to 57 degrees F. The documentation lacked evidence that staff made adjustments or notified maintenance of the out of range refrigerator temperatures.<br><br>A maintenance "Repair Requisition" slip dated 9/12/13 stated, "See administrative nursing staff about refrigerator." The requisition lacked a completion date or action taken to resolve the out of range temperatures.<br><br>An interview with administrative nursing staff C on 9/17/13 at 9:08 a.m. verified the facility expected staff to maintain the medication room refrigerator temperature between 34-47 degrees F as indicated on the "Refrigerator Temperature Log". Administrative nurse C further stated the charge nurse had the responsibility of checking the medication room refrigerator temperature every | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 33<br>day. If the temperature registered out of the parameters, they should report to the director of nursing, and complete a maintenance requisition for repair of the refrigerator.<br><br>During an interview on 9/17/13 at 10:27 a.m., administrative nurse B stated staff should send a requisition to maintenance when the refrigerator temperatures registered out of the desired range. He/she further confirmed the temperature logs revealed out of range temperatures in the months of August and September of 2013.<br><br>During an interview on 9/19/13 at 1:10 p.m., maintenance staff F recalled receiving 2 requisitions for problems with the medication room refrigerator. Maintenance staff F stated he/she adjusted the refrigerator temperatures when he/she knew there was a problem.<br><br>The facility failed to maintain desired temperature parameters in the medication room refrigerator which stored medications for resident use. | F 431 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 34<br>actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 33 residents. The attached hospital processed the long term care residents' laundry.<br><br>Based on observation, interview, and record review, the facility failed to provide a safe, sanitary environment to prevent the spread of infection or disease when staff failed to properly handle and process all residents' laundry, failed to properly dispose of soiled gloves and gowns after handling residents' dirty laundry, and failed to clean resident #35's bathroom according to manufacturer's instructions. The facility also failed to properly utilize gloves while providing care to non-sampled resident #27. | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 35<br>Findings included:<br><br>- During a tour of the attached hospital's laundry room on 9/18/13 at 2:31 p.m., observations revealed a dirty section that contained multiple empty laundry barrels and a residential sized washer with instructions on top of the machine labeled "pre-washer" with no observed laundry in the machine.<br><br>During an interview on 9/18/13 at 2:32 p.m., Laundry Staff Y reported the hospital processed all of the residents' laundry from the long term care unit. Staff Y stated that facility used blue bags for soiled linen that should indicate it contained linen that may have blood, vomit, or other contaminates. Staff Y reported that the long term care unit staff put all of the residents' laundry in the blue bags. Staff Y stated he/she expected the laundry staff to open the blue bags from the long term care unit, sort the soiled linen into like piles as if it contained no blood or vomit, and wash the sorted laundry with water above 160 degrees F (Fahrenheit). Staff Y reported that laundry staff only used the pre-washer machine if they noticed blood, urine, or stool in small amounts.<br><br>During an interview on 9/23/13 at 2:26 p.m., Administrative Nursing Staff B reported the long term care unit bagged all of the residents' laundry in blue bags as the facility expected all the residents' laundry to be handled as if contaminated. Staff B reported each blue bag should be washed in the pre-washer separately prior to being washed in the industrial washers. Staff B denied knowledge that the laundry department currently did not process residents' laundry as expected. | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 36<br>The facility's "Laundry Department" policy, last revised in June 2010, instructed that "isolation linen is so marked and handled according to special contamination prevention procedures... Heavily soiled linens are removed prior to washing by nursing and washed in the pre-wash washer using special laundry detergent."<br><br>The facility failed to properly process all residents' laundry when laundry staff failed to handle specially marked linen as contaminated as instructed in their policy.<br><br>- During an observation on 9/18/13 at 9:41 a.m., Laundry Staff Z wore a protective gown and gloves while walking in the facility's hallway and pushed a linen cart with lids toward the residents' shower room. Staff Z placed loose, soiled clothing into the linen cart, covered the soiled linen, and failed to remove his/her soiled protective gown and gloves. Staff Z walked back to the laundry department through the facility's hallways while wearing the contaminated gown and gloves.<br><br>During an observation in the dirty section of the laundry room on 9/18/13 at 2:31 p.m., 5 protective gowns hung on 2 hooks next to empty soiled linen barrels.<br><br>During an interview on 9/18/13 at 2:45 p.m., Laundry Staff Y stated he/she did not think that laundry staff should wear protective gowns and gloves in hallways but stated the facility expected them to wear them even if the gown or gloves became soiled. Staff Y reported laundry staff only removed the protective gear after they processed soiled linens. Staff Y stated that laundry staff washed the protective gowns once a day and will put soiled gowns back on if they | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 37 | F 441 | | |

needed to process dirty laundry. Staff Y reported that staff hung the gowns up to dry between use in the dirty section to be close to where they process soiled linens.

During an interview on 9/23/13 at 10:10 a.m., Laundry/Maintenance staff F reported the facility expected the laundry staff to remove soiled gloves after handling dirty linens, wash their hands, and put on new gloves prior to the next task. He/she denied knowledge of whether laundry staff should wear contaminated protective gowns and gloves in residents' hallways.

During an interview on 9/23/13 at 1:58 p.m., Administrative Nursing Staff G reported the facility expected all staff to remove soiled protective gowns and gloves then wash their hands prior to walking in residents' hallways.

The facility's "Laundry Department" policy, last revised in June 2010, instructed laundry staff to wear gown and gloves for dirty linen pick-up, sorting, and loading dirty linen. The policy lacked instructions related when to changing soiled gloves and gowns and when to wash their hands.

The facility failed to provide a safe, sanitary environment to prevent the spread of infection or disease when staff failed to properly dispose of soiled gloves and gowns after handling residents' dirty laundry.

- During an observation on 9/18/13 at 11:28 a.m., Housekeeping staff O placed "BetCo" toilet cleaner in resident #35's toilet bowl, scrubbed the toilet bowl, and let the cleanser sit for approximately 1 minute before he/she flushed the toilet. At 11:29 a.m., Staff O sprayed "BetCo Quat" cleanser on the resident's sink and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 38 | F 441 | | |

immediately wiped it off with a clean rag, then sprayed the toilet seat and bowl and immediately wiped them off with the same rag. Staff O failed to clean the bathroom grab bar.

Review of the "BetCo" toilet bowl cleaner revealed the manufacturer recommended to leave the cleanser on the surface for 10 minutes to kill all germs.

Review of the "BetCo Quat" spray cleanser lacked instructions related to how long staff should leave the cleanser on surfaces to kill germs.

During an interview on 9/18/13 at 11:31 a.m., Staff O reported he/she did not know the toilet bowl cleaner instructed to leave it on the surface for 10 minutes or the instructions for the quaternary spray cleaner.

During an interview on 9/23/13 at 11:35 a.m., Housekeeping Staff I reported the quaternary cleanser should be left on surfaces for 10 minutes, each spray bottle should have instructions of use on them, and verified staff failed to follow manufacturer's instructions of the toilet and spray cleaner.

The facility's "Daily Cleaning Duties" policy, last revised in April 2011, instructed staff to clean the residents' bathrooms as follows: "wipe handrails, doorknobs. Pour toilet bowl cleanser under inside rim and let set... go back to the toilet and clean the inside of the bowl with toilet brush and flush." The policy failed to instruct staff to follow manufacturer's instructions of cleansers.

The facility failed to ensure a safe and sanitary environment to prevent the spread of infections

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 39<br>and disease when staff failed to properly clean resident #35's toilet and sink according to the manufacturer's instructions.<br><br>- During an observation on 9/17/13 at 5:20 p.m., licensed nurse K prepared to administer insulin to resident #27, after washing his/her hands, nurse K obtained a pair of gloves, dropped one of the gloves on the floor, then picked the contaminated glove off of the floor and placed the gloves on his/her hands. Licensed nurse K drew the insulin from a multi-dose vial, went into the resident #27's room and administered the insulin while wearing the glove he/she dropped on the floor.<br><br>During an interview on 9/17/13 at 5:30 p.m., licensed nurse K stated he/she should have used a new glove instead of the one that dropped on the floor.<br><br>An interview on 9/23/13 at 2:54 p.m. with administrative nurse B confirmed staff should not use gloves that have fallen on the floor when providing cares to residents.<br><br>The facility failed to use gloves as indicated by accepted professional practice when staff wore a contaminated glove while administering insulin. | F 441 | | |
| F 465 SS=F | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This Requirement is not met as evidenced by:<br>The facility had a census of 33 residents. The facility had a sidewalk from the front entrance of | F 465 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 465 | Continued From page 40 | F 465 | | |

the facility that led to a sidewalk extending to the North and South, parallel to the building.

Based on observation, interview, and record review, the facility failed to provide a safe environment (uneven, pitted, and eroded sidewalks posing a fall hazard) for residents, staff, and visitors.

Findings included:

- An accident investigation dated 7/23/13 at 6:00 a.m., by licensed nursing staff DD reported the resident #33 was found lying on his right side on the east lawn. According to the report, the resident stated he/she tripped over the uneven part of the sidewalk and landed on his/her head. The resident complained of neck pain and the facility transferred the resident to the Emergency Room.

An observation on 9/23/13 at 9:30 a.m. of the sidewalk in front of the facility revealed areas of pitted, eroded, and uneven walkways. The sidewalk area leading from the front entrance to the North/South sidewalk had 3 uneven areas. The sidewalk parallel to the facility that extended North had 2 areas of uneven surface and had pitted/eroded areas. The North sidewalk and the front entrance had patched/repaired areas in the concrete. The sidewalk parallel to the facility that extended South had an uneven area. The uneven surfaces and pitted/eroded areas posed a trip/fall hazard.

During an interview on 9/23/13 at 10:10 a.m., maintenance staff F stated the patched/repaired area on the Northward sidewalk, parallel to the building, was the location where resident #33 fell on 7/23/13. Staff F confirmed the sidewalks in

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E015 | A. BUILDING _____ B. WING _____ | 09/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRISELL MEMORIAL HOSPITAL LTCU | 330 S VERMONT PO BOX 268 RANSOM, KS 67572 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 465 | Continued From page 41<br>front of the building and the North/South sidewalk had uneven surfaces and pitted/eroded areas that posed a trip/fall hazard to anyone walking on the sidewalk. Maintenance staff F further stated he/she did not routinely assess the condition of the sidewalks as a part of his/her preventative maintenance plan.<br><br>An interview with administrative nurse B on 9/23/13 at 11:30 a.m. confirmed the uneven, pitted, and eroded areas in the sidewalks in front of the facility could be a trip/fall hazard for the residents, staff, and visitors.<br><br>The facility failed to maintain the sidewalks in front of the facility in order to prevent falls for residents, staff, and visitors. | F 465 | | |